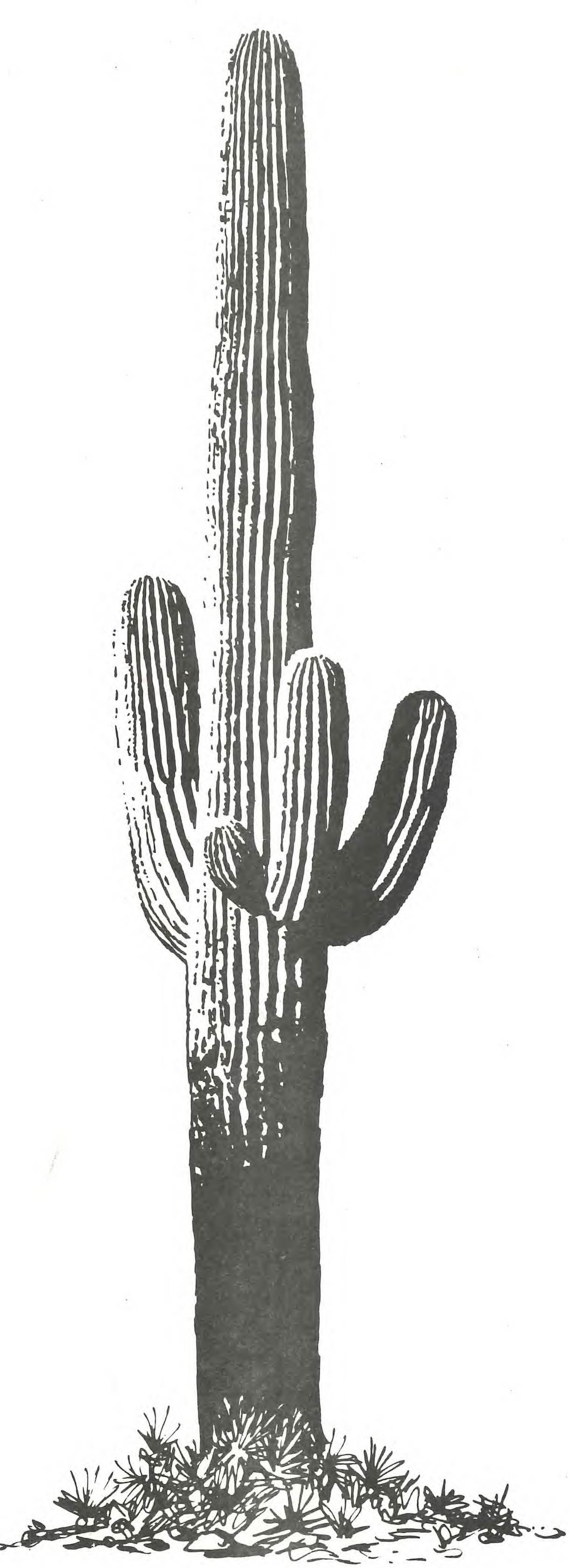

Arizona State Hospital Advisory Board Annual Report

January 1985 -
December 1985

ARIZONA DEPARTMENT OF HEALTH SERVICES
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FIRST ANNUAL REPORT OF
THE ARIZONA STATE HOSPITAL ADVISORY BOARD

ADVISORY BOARD STRUCTURE AND SCHEDULE

The current Arizona State Hospital Advisory Board was created by Chapter 127 of the Law of the Thirty-Sixth Legislature, signed by the Governor on April 17, 1984. The act creating the Board fixed its membership at eleven, with the requirement that various specific interests be represented on the Board. The initial appointments were made in January, 1985; the initial members and the groups they represent are:

Arnold G. Smart, Tucson (Family of ASH Patient)
Margaret Walsh, Phoenix (Family of ASH Patient)
Geneva Sutton, Phoenix (Non-health-care provider)
Kent Corbin, Phoenix (Insurance Industry)
Dwayne Ross, Phoenix (Attorney)
Honorable James McDougall, Phoenix (Juvenile Judge)
Robert Fleming, Tucson (Public Fiduciary)
Romelia Carbajal, Phoenix (Corporate Industry)
Honorable Michael Brown, Tucson (Superior Court Judge)
Dr. Marilyn Heins, Tucson (Physician)
Thomas Callan, Phoenix (Banking Community)

The Board held its first meeting on April 23, 1985, and has held meetings monthly since that date, including one evening meeting at which the public and mental health-care providers were invited to address the Board with their concerns about the State Hospital and the continuum of mental-health care in Arizona.

Although the statute creating the Board was adopted in early 1984, the combination of a delayed effective date and the failure to appoint Board members in a timely manner prevented the issuance of the first annual report scheduled for January 1, 1985. This report is, therefore, the First Annual Report of the Arizona State Hospital Advisory Board.

MEETING THE NEEDS OF STATE HOSPITAL PATIENTS

A. Commitment/Admission Rates

The admission rate for new patients in 1985 slowed noticeably from the 1984 average of nearly 63 patients per month. For the first nine months of 1985, the average was just over 53 new patients per month. The total census dropped from 491 at the end of December, 1984, to its present level of 465. For more detailed statistics concerning admissions, discharges and State Hospital populations, see the attached Table #1.

Three facts should be kept in mind, however, in evaluating the effect of the reduced admissions and census in 1985. First, the comparison to 1984 figures is misleading, since those figures appear to represent the end of a period of rapid growth in ASH census begun by the 1983 liberalization of the commitment law. Indeed, the census at the end of December, 1983, stood at only 400 patients; the current population represents a 15 percent increase over that two-year period.

The second factor making comparisons difficult is the uncertain effect of 1985 changes to the commitment law. The most recent round of changes has been widely hailed as another liberalization of the commitment standards and was expected to produce a substantial increase in commitments. In the four months since those changes, it has not been possible to guage their effect. There is no early evidence of a crush of new admissions, but some delay in effect might reasonbly be expected in any event.

Finally, it should be noted that the decrease in ASH population actually occurred in two periods in 1985--April and July/August. The first of those periods corresponds to the consideration and adoption of the new commitment law, and the second to its effective date. Both might be ascribed to ASH staff's vigorous efforts to reduce the census as much as possible to make way for the expected crush of new patients (which has not as yet materialized).

B. Adolescents

By contrast, the treatment of adolescents at ASH has remained quite constant over

the past several years. Although mandated to provide psychiatric services for adolescents, ASH presently has room for only 22 patients. The actual number of patients in the Adolescent Treatment Unit (ATU) has increased from 17 at the end of 1984 to approximately 20 today. Due to poor salaries, especially as compared to similar positions with the Department of Corrections, teacher turnover and staff shortages on the ATU remain high.

C. Physical Plant

Since there is only one campus of the State Hospital, it is relatively easy to assess the size and condition of space available for housing and treating ASH patients and administering the programs. The buildings currently in use by the State Hospital range in age from nearly thirty to almost one hundred years old. No construction has been undertaken since the major thrust of deinstitutionalization began over two decades ago; most of the buildings date from a period when design considerations included the then-current practice of housing all patients together by county, regardless of condition or needs. The practice of psychiatry has changed radically from that time even though the building floor-plans have not; as a result, recreational areas are cramped and inadequate, sleeping and living areas are not adequately private and good treatment and therapy constantly await the relocation of administrative offices or storage space.

The specifics of an overcrowded and antiquated physical plant translate into problems that are all too real for staff and patients. Aging pipes and temperature control valves make it impossible to properly regulate water temperatures in sinks or showers. The upkeep costs on the central cooling system that serves many of the main ASH buildings are increasing with the age of the system itself and the tunnels connecting the various buildings on the system; those increased costs translate into a shortage of funds to repair roadways and parking lots, which consequently are dangerously pitted and deteriorating. The 20-year-old laundry facility (which also serves some Department of Corrections programs) is so obsolete that parts are often not available. In spite of the fact that a large segment of the State Hospital population is also physically handicapped or disabled, the buildings and grounds of the campus are largely inaccessible to wheelchairs, walkers or other aids. Many of the facilities are unsafe or inaccessbile to the visually impaired as well.

More than just antique, the ASH grounds are also overcrowded. After the deinstitutionalization movement reduced the Hospital census to a fraction of its former size in the early 1960s, ASH went through a period of uncertainty as to how to best use the facilities for the benefit of the mentally ill of Arizona. Since the Department of Corrections desperately needed new space, it seemed logical in 1979 to begin a program of leasing buildings to DOC. Unfortunately, the execution of those leases preceded by only three years a dramatic return to inpatient treatment of the mentally ill, which has resulted in increasing the ASH population by one-third in the past five years.

Now that five years of reconstruction has turned many ASH buildings into prisons, simply canceling the leases (which ASH clearly has the power to do) is hardly the most reasonable or cost-effective way to regain space. Even if the cost to the DOC of finding alternative space is ignored, the cost of renovation of the buildings to make them once again usable for patient care for the State Hospital would almost certainly be prohibitive for the State. It is important to keep in mind, however, that the original grant of land to the State for the State Hospital grounds has been construed as creating a trust for the benefit of the mentally ill of Arizona, and the use to which the land is put should comply with the fiduciary responsibility which the State, as trustee, has to that group. Consequently, even though the buildings are no longer useful as a mental hospital, the State should exercise great care in using the premises for purposes that do not clearly benefit the mentally ill; the present practice of ignoring that proscription altogether is an invitation to a lawsuit on behalf of that class.

In a related vein, it is well established that the best psychiatric care is normally that care which is delivered close to the patient's home and family. This is especially true for children and the young chronically mentally ill, for whom family therapy may be an essential part of the treatment program. Whatever reasons may have existed in 1885 for the creation of a single state hospital in Phoenix, the better clinical practice would be to have a variety of settings and levels of care, spread throughout the State in an effort to maximize the possibility that a patient can receive the appropriate care reasonably close to his or her family and friends. With a single, centralized State Hospital in near-downtown Phoenix, those goals are impossible to reach.

D. Staffing

During the past two years of dramatic growth in ASH population, the staffing patterns have simply not kept pace. While a reasonable level of staffing seems always to be attainable, the minimum of 1.8 staff members per patient set by the Hospital Superintendent to ensure compliance with the standards of the Joint Commission on Accreditation of Hospitals (JCAH) remains elusive. The causes of this problem are multiple; as might be expected, low morale and high turnover are endemic. At least some of the problem, however, stems directly from the budgeting practices of the Department of Health Services, which require the State Hosptial (at least during periods of expansion) to perpetually play "catch up" by waiting for a demonstrated need before beginning the lengthly practice of securing additional staff. The chronic shortage of staff, in turn, feeds the pre-existing morale and turnover problems, and the resulting cycle seems obvious and inevitable in the circumstances.

E. Accreditation

In 1984, for the first time in several years, ASH was accredited by the JCAH unconditionally. Nonetheless, several areas of concern were pointed out by the Committee, and conditions have deteriorated since. Major concerns about the current accreditation cycle (which began in November, 1985) include the low staff/patient ratio, overcrowding and the adequacy of documented treatment plans. While progress is being made in the staff/patient ratio and documentation of treatment plans, it should be noted that ASH has been "grandfathered in" on square footage required per patient; if standards for new facilities were applied, ASH would not have recieved accreditation in 1984. Not only has space per patient been reduced in the intervening year, but JCAH is expected to begin phasing out the "grandfathering" provisions.

PARTICIPATING IN THE BEHAVIORAL HEALTH CONTINUUM OF CARE

A. Behavioral Health Plan

Early in 1985, the Department of Health Services developed and announced the implementation schedule for a comprehensive, statewide behavioral health plan.

The essential structure of that plan was to transfer administrative responsibility and accountability for community mental health and substance abuse programs to the local communities, by virtue of the selection of a local administrative entity in each region of the State.

Since the plan had been developed and adopted prior to the first meeting of the ASH Advisory Board, it is difficult to say with any certainty whether State Hosptial input was specifically sought in designing the plan. In any event, the Superintendent of the State Hosptial at the point at which ASH involvement would have been useful resigned late in 1984, and his replacement was not selected until July, 1985, by which time the plan was already in effect. It seems reasonably safe to suggest that the ASH administration was not heavily involved in the development of the Behavioral Health Plan.

One of the philosophical difficulties that ASH has dealt with for some years is the tendency of the Department of Health Services and community providers to view the State Hospital as a placement of last resort, to be utilized only when all treatment efforts have failed in an individual case. In keeping with that notion, there seems to be a community perception that, once a patient is sent to the State Hospital, he or she should stay there until the community agency feels he or she is ready for discharge. This, in turn, fosters a notion of the separateness of treatment programs; community agencies tend to expect the State Hospital to agree with their diagnosis and treatment plan, but not to bother the community agency with the actual treatment itself. In turn, the State Hospital tends to view itself as the placement of last resort as well, and to take seriously the legal notion that patients who are capable of being treated in the community can not be kept at the State Hospital.

What all this means in a practical sense is that the already fragmented mental health treatment system is further fragmented by the perceptions of the State Hospital's role held by both community agencies and ASH staff. As a result, communication about impending transfers into and out of ASH is poor, and the notion that one or the other could ask for advice or assistance from the treatment professional on the other side of the ASH fence is almost unheard of. Unfortunately, the State Behavioral Health Plan not only continues that separation, but heightens it dramatically. In a system already starved for dollars, the Plan adds an extra level of bureaucracy within regions, but does not address each region's use of ASH. It

compels more competition among community agencies and leaves a State Hospital commitment as the only available mechanism to get rid of a patient who is difficult to treat.

One positive possibility was written into the 1983 amendments to the Mental Health Code. The State Hospital is now permitted to appear at initial commitment hearings to argue against commitment to ASH or, if appropriate, to urge modification of the commitment order. Unfortunately, ASH's single attorney must be available for consultation on a wide variety of subjects, and to conduct the State's case in most commitment hearings, and consequently, the possibility of meaningful intervention in the proceedings in fifteen counties is slim indeed. Furthermore, individual counties are encouraged to use ASH as a "dumping ground" by the simple expedient of not providing alternative services. Rather than encouraging cooperation among treatment professionals dedicated to finding the most appropriate and promising treatment plan for individual patients, the fragmentation of the system and the new competition for resources introduced by the State Behavioral Health Plan guarantees the rampant practices of buck-passing, dumping and "turfing" patients. In short, the Plan created a new layer of administration without reducing or modifying the administrative staffing of the Department of Health Services, and without increasing the already inadequate funding for services.

B. Joint Legislative Committee on the CMI

After more than a year of complete inactivity, and faced with the deadline of a Superior Court mandate, the Joint Legislative Committee on the Chronically Mentally Ill began a series of meetings in mid-1985. The goal of the Committee was to develop a mental health system that would respond to the needs of the mentally ill of Arizona, especially the chronically mentally ill. The Joint Legislative Committee has been willing to accept input from the ASH Advisory Board and, presumably, the staff of the State Hospital itself. It is too early to tell whether that Committee is prepared to tackle the problem of integrating the State Hospital into the continuum of care for the mentally ill.

C. ASH Participation in Community Mental Health Care

Although the State Hospital is clearly the main recipient of government moneys to

provide mental health care in the State, it has never taken a leadership role in the development of appropriate programs and facilities. The State Hospital does not now have any sort of outreach or outpatient counseling program, and the only attempt in recent years to provide any sort of bridge to community mental health treatment has been the commendable but limited Transitional Living Program. The causes of this failure to lead the way in mental health treatment may well include the attitude of the Department of Health Services and ASH Administration, the chronic shortage of dollars, the perception that the State Hospital is a treatment mode separate from the treatment received in the community, or some combination of those factors. Whatever the historical reason for the lack of leadership in mental health care, the fact remains that the largest concentration of psychiatric and mental health experts employed by the State has failed to take any responsibility for the development of a strong, adequately funded community mental health treatment system.

MAJOR PROBLEMS FACING THE ARIZONA STATE HOSPITAL

A. Space and Funding

The physical plant of the State Hospital is aging and in most cases already antiquated. The need for construction of new facilities, both to house new patients and to replace existing structures, is acute. This is especially true given the inevitable delays attendant on the construction of new buildings by the government. Any plan that would speed this process, including the possibility of involving the private sector, should be encouraged.

In addition to the need for money for new buildings, there is a very real, immediate need for increased expenditures on mental health programs. Not only is Arizona shamed by its last place ranking on mental health spending generally, but it has recently been revealed that we rank 46th of the 50 states in spending on state mental hospitals. Reorganization and planning are essential to the development of an adequate mental health treatment sytem, but so is the expenditure of sufficient money to permit any system to address the problem.

B. Children and Adolescents

As noted elsewhere in this report, the program for treatment of the adolescent mentally ill is limited to 22 patients. Despite the statutory mandate to the State Hospital to provide such services, there are no programs at all for children under the age of twelve.

C. Limited Outpatient Programs

Even if the State Hospital were fully integrated with the rest of the behavioral health continuum of care in the State, the problem would remain that there are simply not adequate programs or placements for many of the State Hospital residents who might benefit from alternative treatment. The result is expensive; State Hospital care will almost never be the least expensive alternative in individual cases. The result is also a tragic waste of human potential and individual development.

The State Hospital must take a leadership role in the development of outpatient and transitional programs to serve its residents. Failure to do so will mean the continued uncontrollable growth of its own population and will encourage the fragmentation of services presently plaguing mental health care in this State. The State Hospital will not take such a leadership role, however, without the active support, encouragement and assistance of the Department of Health Services and the State Legislature.

D. Geographic Location

While it might not be true to suggest that Arizona is unique among comparable states for our continued commitment to a large, central state mental hosptial, it is certainly true that the trend is away from such a facility and toward treatment in the patient's community. The State Hospital Administration should be encouraged to plan for the eventual decentralization of the existing facility, perhaps in conjunction with the new construction and programmatic changes that will be needed in any event.

One way to minimize the cost of regionalized hospitals might be to effect the sale

of the ASH grounds at 24th and Van Buren in Phoenix. The proceeds from such a sale would have to be properly invested, keeping in mind the fiduciary duty owed to the mentally ill of the State of Arizona by the State Director of Health Services. It is important to keep in mind, however, that the construction of regional facilities can not await the completion of a lengthy planning and review process concerning sale of ASH grounds; the development of a regional treatment plan should proceed immediately and not be directly linked to a possible sale of the grounds.

E. ASH Status in Behavioral Health Planning

Many of the problems confronted by the State Hospital can be traced historically to the treatment of behavioral health issues generally and ASH particularly at the hands of the State Department of Health Services. Put succinctly, behavioral health planning has never been a first priority of the Department of Health Services. The good ideas and plans that might have come from the professional staff of the State Hospital have been stopped by the Department's resistance to ASH administrators talking directly to legislators or the Governor's Office. As noted elsewhere in this report, the apparent inability of the State Hospital to plan for its future budget needs can be largely attributed to Departmental budget restraints. The conclusion seems inescapable that the State Hospital and, indeed, the entire mental health system should report directly to the Governor; more to the point, the system should be relocated outside the Department of Health Services. Failing that alternative, the mental health structure should be strongly and independently organized within the DHS administration, with appropriate guarantees that the needs of the mental health treatment community and its patients can be relayed to the appropriate governmental entities. In either kind of structure, the State Hospital should be an integral part of the organization, not a separate, adjunct organization.

F. Psychiatric Nursing Care

A specific need exists for the development of some kind of psychiatric nursing care facility in Arizona. The 100-150 ASH patients who are elderly, frail and phycially incapacitated could be better and more cheaply treated in such a facility. The major impediment to development of such a facililty in the past has been the disagreement between the State and Counties over who should pay the costs of care for its patients. While jurisdictions quibble, the taxpayers of the entire state and,

more acutely, the elderly mentally ill suffer. Immediate steps should be taken to remove most of this class of patients from the State Hospital grounds into the few existing facilities, a new State facility or beds in private facilities under an ASH contract.

RECOMMENDATIONS

A. Budget Recommendations

1. Increased Funding - The State Hospital requires additional funding, even to discharge the duties already imposed upon it. Funds are desperately needed for routine maintenance, which has been deferred for years, in most cases, and decades in some. Funding levels need to be increased to permit reclassification of ASH positions to compete with private sector and other public-sector positions.

2. Budget Flexibility - In order to permit planning to progress in an orderly fashion, the budget process must be modified. The State Hospital must have a mechanism to make reasonable projections of growth and renovation needs during the remaining budget year after legislative approval of the baseline budget.

3. Planning - The Department of Health Services, if it is to continue to control mental health treatment, must encourage planning for future construction and growth. Plans should be presented to the Governor and the Legislature, and should consider not only financial but programmatic and therapeutic concerns. A master plan for the direction of mental health treatment in Arizona should be formulated, addressing decentralization of ASH functions, administrative control of mental health programs and related issues. This process is largely a budgetary process, but the practice in recent years has been to project only what budget needs exist at the time of budget submissions and for the purpose of maintaining the present inadequate system.

B. Legislative Recommendations

1. Child/Adolescent Treatment - A major shortcoming of the State Hospital and

the Department of Health Services is found in the treatment of children. The space and staff allocated to this function by the State Hospital is grossly inadequate. Major efforts must be made to adequately fund and compel the development of a substantial Child/Adolescent Treatment Unit, though the Unit need not be housed on the ASH grounds. These efforts should be accompanied by a thorough needs assessment to determine how many beds, facilities and programs are necessary to adequately serve the needs of mentally ill children and adolescents.

2. State/County Responsibility - The bickering between State and County agencies over funding and programs must be stopped. Even if the State has to pick up the cost, nursing care for the feeble, elderly mental health patient is clinically appropriate and less expensive for the taxpayers. Counties, on the other hand, should be required to pick up their share of the cost of acute and medium-term mental health treatment, either by State assessment or legislative mandate.

3. Decentralization - The legislature should endorse, and direct this Board to formulate, a plan for decentralization of the State Hospital. The development of a decentralization plan should include the active involvement and cooperation of the Department of Health Services, and should provide for a regional treatment center in Tucson and an assessment of the need for additional centers in Flagstaff, Yuma or other outlying areas. It should provide for the separation of patients by rehabilitative potential, physical and medical needs.

Considerations central to the development of a decentralization plan should include the possibility of sale of the present State Hospital grounds. Existing State Trust lands should be reviewed for possible sites. Some thought should be given to combining State Hospital services with existing County and private efforts, including the possible joint use of existing facilities.

One specific concern about decentralization should be separately mentioned. Any change in the locale of treatment should not be accompanied by further fragmentation of the administration of mental health services. The administrative responsibility for the entire State Hospital system must be centrally located and the lines of authority clear and direct.

C. Other Recommendations

1. ASH Leadership - The State Hospital should be expected to take a leadership role in developing and monitoring outpatient treatment programs, if for no other reason than the practical necessity of creating placements for its patients. Rather than the detached end of a failed treatment plan, the State Hospital must be seen as an integral part of the mental health treatment continuum, and the expectation developed that ASH treatment will normally be followed by a return to the community.

2. Behavioral Health Plan - If a comprehensive statewide behavioral (or mental) health plan is appropriate, the State Hospital should be part of that plan, both in its creation and its structure. Individual counties or communities should be rewarded by the Plan for lower usage of ASH, and the case management system should treat ASH placement and involve ASH staff in the same manner that other agencies are dealt with.

3. Administrative Reorganization - The present structure of the Department of Health Services, even with the creation of a Division of Behavioral Health, is not conducive to mental health planning or oversight. A separate Department of Mental Health should be created, responsible directly to the Governor and with its own budget. If this is not financially or legally feasible, the very minimum requirement is for a separate Division of Mental Health, with the exception on the part of the Executive and Legislative branches that the Director of the Division will deal directly with the Governor and Legislature. Forcing mental health issues to compete for attention with environmental health and alcoholism and drug abuse programs has proven to be unacceptable.

Whatever administrative entity is responsible for the delivery of mental health services, substantial efforts should be made to reduce the current fragmentation of the system. The Arizona State Hospital Superintendent should become a key player in planning and administration of mental health care. In recognition of the need for coordinated efforts to cope with mental illness, this Board should have its responsibility expanded and redefined to include review of State mental health programs generally, while maintaining the specific

responsibility to advise the State Hospital Superintendent. Membership of this Board may have to be expanded to deal with expanded authority.

SUMMARY

In its first year of active existence, the Arizona State Hospital Advisory Board has found much that is right with the mental health treatment system in Arizona. Among the things which the Board feels should be commended is the professional, caring and cooperative attitude displayed by State Hospital employees, who are often called upon to do the impossible, and frequently seem to succeed. This is especially notable when the abysmal level of funding for mental health care is considered. It is heartening to note that the Joint Commision on Accreditation of Hospitals and the Medicare review process have both indicated that ASH meets their respective standards for annual renewal. The arrival of a new Hospital Superintendent promises even better performance in the future.

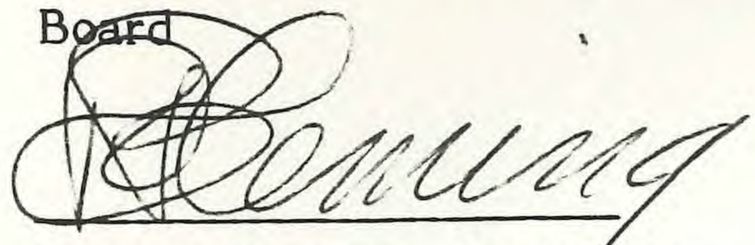
However, no amount of good news can overcome the reality of an underfunded, fragmented and unsupervised mental health treatment system in Arizona. It is frequently reported, for instance, that Arizona ranks at the very bottom of the states in per capita expenditures on mental illness. To bring the problem into sharper focus, the legislature should keep in mind that the modest goal of reaching the median position among the states in per capita spending on mental health issues would require an increased annual expenditure of approximately 36 million dollars.

The adoption of a statewide behavioral health plan, far from solving these problems, appears to have exacerbated them, and added drug and alcohol treatment programs to the competition as well. The failure of the State Hospital and the Department of Health Services to lead the mental health community is at least partly to blame for the fragmentation. The inadequate funding is the result of decades of failure to address the problem at both the Department of Health Services and the Legislature.

The threat of a Superior Court order compelling State action, together with efforts of mental health and child advocacy groups and the Legislature itself, promises the real

possibility of substantial improvement in the system and its funding. The Arizona State Hospital Advisory Board strongly urges the Legislature to lift Arizona out of the basement of mental health funding and to consider the other programmatic changes recommended in this report.

Respectfully Submitted By
The Arizona State Hospital Advisory
Board



Robert Fleming, Chairman